Are health care systems insensitive to needs of suicidal patients in times of conflict? The Kashmir experience

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Abstract

Suicide and attempted suicide is an important health issue and the number of people who die of suicide exceeds that of conflicts. Kashmir has been suffering from a low intensity war since last 20 years in which thousands have been killed or injured. There has been phenomenal increase in cases of psychological disorders along with suicide and and suicide attempters. Suicide in a conflict zone is viewed with indifference due to focus on the physical part of trauma. Difficulties faced by the suicidal patient and his attendants are seldom highlighted. 1408 patients who reported to emergency room for suicide attempt from 2000 to 2008 were taken for the study. All the patients underwent the hospital protocol for poisoning management. Patients were subjected to detailed psychiatric evaluation and questions were specifically asked about the difficulties encountered during management. Most of the cases were females with 92.11% belonging to the Muslim religion. 76.20% cases were from a rural background. 32.5% had been referred because of the lack of specific antidotes. Forty-three percent required arrangement of transportation by their own family members. Fifty-seven percent had been stopped for security checks along the way. Seventy-three percent felt that the attitude of the staff hostile. Twenty-three percent of patients had to share a bed. Almost all patients were questioned by security agencies within the hospital. More than 68% patient reported hostility amongst their neighbors. Suicidal poisoning is a significant health problem in Kashmir and management of these cases is fraught with difficulties across the spectrum of health care. Educating the doctors at primary care about first aid, improvement in community services followed by long term resolution of the conflict would go some way in alleviating the difficulties faced by a suicidal patient and his family in a conflict zone.

Introduction

Suicide is a major health issue and often takes up a significant portion of the health budget. The WHO estimates that one suicide occurs approximately every minute and an attempt at the suicide is made every 3rd second, thus number of people killed by suicide is more than the armed conflict.[1] A review of the literature shows that attempted suicide rates vary from 100 to 300 per 100,000 with a preponderance of those attempting suicides being females.[2] Since last 20 years Kashmir has been in grip of a low intensity war in which thousands of people have been killed or injured. Around 4000 people have also disappeared according to official figures where as non official figures are higher.[3,4] Although exposure to violence leads mainly to physical injuries, it has also potentially important implications for mental health.[5] Violence has affected nearly everybody living in Kashmir. The high levels of violence confronted by the Kashmiri population have resulted in high prevalence of mental health problems. A population survey found a lifetime prevalence of traumatic events of 59% among the inhabitants surveyed.[6] Along with increase in psychological disorders there has been a phenomenal increase in suicide and suicidal attempters.[7] In another study about one-third of those surveyed had thoughts of ending their life in the past thirty days.[8] Suicidal attempts account for 23% for all psychiatric visits to an emergency room.[9] Acute sucidality tops most admission criteria and is a justification of may admissions.[10] Suicide in a conflict zone is often viewed with indifference in our culture which has been further compounded by the occurrence of a prolonged armed conflict. This is more so as most of the focus of all the professionals and paraprofessionals seems to be on the *physical* trauma including injuries and disabilities rather than the psychological part. While as there have been many studies regarding the factors that lead to suicide , the patient and the attendant experience post attempt in a conflict zone has been rarely studied. The purpose of this study was to find the difficulties faced by the suicide attempters and their attendants in accessing and receiving health care in a conflict zone.

Materials and Methods

We studied 1408 patients received in Government SMHS hospital emergency room for suicide attempt over a period of 8 years from 2000 to 2008. Our cohort of patients included those who were taken to the nearest medical facility from their home and were then referred to the Government SMHS hospital for further management. All the patients had to travel more than 25 km to receive medical aid. All the patients underwent the hospital protocol for poising management as indicated which included gastric lavage, antidotes, supportive therapy and other required measures. The socio medical history was obtained from the patients, their attendants and the accompanying legal administrators. Only those patients were retained for the study in whom subsequent investigations supported the intake of a poisonous substance. Patients with poor cooperation and patients leaving the hospital against medical advice were not included in the study. After stabilization, the patients were subjected to a detailed psychiatric evaluation to understand the basic precipitating cause besides treating or counseling. Interviews were conducted of the patients as well as their legal guardians. This was also done at the first three follow ups. Even though the questions were of varied nature, the difficulties encountered that were directly or indirectly attributed to the conflict were recorded separately. 1408 patients met the required criteria and their answers and experiences recorded.

Results

1408 patients fulfilled the selection criteria out of which 883 were females and 525 were males. Majority of these cases 1297 (92.11%) belonged to the Muslim religion. The sociodemographic data of the patients are shown in Table 1. Among the substances used for suicidal purposes, Organophosphorous compounds were

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the most commonly used i.e. 62.59%, Rodenticides 21.36%. Drugs like benzodiazepines, antihistamines, antidepressants in 12.23% &others in 3.82%. the psychiatric morbidity of the patients has been shown in Table 2. Of the 1408 cases almost all reported that the poison they had used was easily available to them and no special effort had been made at the procurement. Sixty-three percent of those who had taken benzodiazepines, antidepressants reported that they themselves or a family member was taking these drugs due to symptoms brought on directly by turmoil related factors. At the primary care level, 32.5% had been referred because of the lack of specific antidotes. This was particularly seen in cases who had taken benzodiazepines, antidepressants, and rodenticides. Sixty-five percent patients were referred indirectly to our hospital after receiving initial care at the primary health center, sub district hospital or the district hospital. Out of this group 43% required arrangement of transportation by their own family members. Fifty-seven percent were transported in the government ambulances with 11% of these having to wait for more than hour as the driver was not easily contacted or the ambulance did not have fuel in the tank. Of the 1408 cases who were questioned about the speed of the transport 57% revealed that they had been stopped for security checks along the way with one or more stoppages. Thirteen percent had been stopped more than thrice.

Table 1. Socio demographic profile of patients.

	Number	%
Gender		
Males	525	37.28
Females	883	62.71
Age		
<15	184	13.06
16-30	851	60.44
31-45	267	18.96
>45	106	7.52
Marital status		
Married	342	24.28
Unmarried	989	70.24
Divorced	52	3.69
Separated	25	1.77
Domicile		
Rural	836	59.37
Urban	267	19.03
Semi urban	305	21.66
Economic class		
Upper	239	16.97
Middle	901	63.99
Lower	268	19.03
Family status		
Joint	536	38.06
Nuclear	645	45.80
Extended	227	16.12
Education		
Illiterate	127	9.01
Primary level	164	11.64
Undergraduate	759	53.90
Graduate	328	23.29
Postgraduate	30	2.13
Occupation		
Student	760	53.97
Home makers	464	32.95
Self employed	121	8.59
Government employed	63	4.47
Religion		
Muslim	1297	92.1
Hindus	28	1.98
Sikhs	59	4.19
Others	24	1.70

Amongst the cases who reached our hospital, the attendants of 73% revealed that they felt that the attitude of the staff was hostile towards the patient as well as the attendants. All of them felt that they were treated with suspicion. Seventy percent reported that an important staff member in the poison management team was not easily traceable. Twenty-three percent of patients had to share a bed after admission with another patient or had to be kept on the floor in the ward. Beds for these patients became available only after 24-48 hours. Almost all patients were questioned by security agencies about the circumstances of the poisoning within the hospital creating a real atmosphere of fright amongst the attendants. More than 68% patient reported hostility amongst their neighbors after their return from the hospital. The hostility among the neighbors was a manifested as reluctance to talk with the victim, avoidance of contact, decreased socializing, angry looks and even swearing. This was particularly seen among the elderly but less in the younger age counterparts. Even after a prolonged follow up most cases felt a distinct sense of hostility among their neighbors. This was reported as the main cause of reluctance in continued follow up to the psychiatry department of our hospital.

Discussion

Kashmir has been suffering from a low intensity conflict for the last 20 years. The fatalities, injuries and disabilities suffered during attacks and fighting are obvious examples of the impact of conflict.[3,4,6,7,8] However, there are also health consequences from the breakdown of services. These indirect consequences may remain for many years even after a conflict ends. With the decline of the economy, constant fear and uncertainty the stress levels in the valley have become considerably higher. Due to the tenuous nature of our medical resources sometimes trivial injuries cause death due to the delay in intervention adding to an already stressful environment. No study about the problems facing suicidal poisoning cases and their attendants vis a vis management problems has been conducted in an conflict zone. There has been approx. 60% increase in suicide rate world over the last several years,[1] a recent study in Kashmir has found that the number of suicidal attempts has increased more than 250% over the last 18 years compared with the pre turmoil period.[7] This increase can be seen as a result of overwhelming of the coping strategies due to excessive external stresses. Vicious circle of violence along with insecurity and loss of job opportunity has provided a very fertile ground for attempting suicide. Insurgency situations like ours have a few peculiar problems which may or may not be seen not seen in normal type of settings. From the initial availability of poisonous substances to the problems in the hospital these seriously undermine the health care and subsequent management. More than 95% patients in our study were referred directly or indirectly to a tertiary care center. A health care system is one of the earliest casualties of the social and economic disruption in conflict. This thing is reflected in the absence or decreased medicines, staff and infrastructural facilities including ill equipped primary and secondary health centers. These difficulties are compounded at the primary centers by non availability of ambulance services due to lack of petrol, absence of driver or use of the vehicle for purposes other than it is supposed to be used for. All the above factors lead to high percentage of patients being referred along with the delay in referrals which was more than one hour in 11% of our patients.

The hallmark of a conflict zone is establishment of check points at frequent places leading to delay in reaching hospitals. patients from far flung and border areas particularly have to face lot of inconvenience and greater number of

Table 2. Psychiatric Morbidity in suicidal attempters.

S.No.	Diagnosis	N	%
1.	Adjustment disorder with or without depressive features	510	36.22
2.	Depressive disorder	375	26.63
3.	Post traumatic stress disorder	129	9.16
4.	Panic disorder	42	2.98
5.	Personality disorders	101	7.17
6.	Substance abuse	51	3.62
7	Bereavement/grief reaction	64	4.54
8.	Schizophrenia & other psychotic disorders	71	5.04
9.	No identifiable cause	46	3.26
10.	Others	19	1.34

check points to reach the hospital leading to delay and subsequent increase in morbidity and mortality. In our study more than 57% of the patients and their attendants had to face this problem.

Twenty-three percent of our patient population could not get a bed in the emergency or had to share one with another patient. This non availability of emergency beds is due to over burdening of hospital resources by continuous fighting. In addition to the routine emergency patients both medical and surgical, a constant flow of blast or bullet injury victims puts tremendous strain on the hospital resources. Whereas some of these patients can be easily managed at the primary care they are invariably referred either due to collapse of these institutions or the doctors there want to play *safe*. This is in addition to the patient *preference* for the tertiary care at place like ours, where they feel that a better care is available. These all lead to very high bed occupancy rates particularly of the emergency beds. About 73% of our study group felt the attitude of staff hostile towards them. *In sensitiveness* and *desensitization* of the staff towards sufferings of suicidal patients may be due to repeated traumatic killings. This can be also due to either exhaustion due to long working hours or presence of non trained staff at a place where a technical person could have handled better. Absence or paucity of the equipment adds to the problem. Many times deliberate self harm is taken as an attention seeking behavior by the staff thus leading to thinking that these patients are just a *wastage* of time. This is a very important factor in successful outcome for a suicidal patient. These problems are often due to a lack of clarity among the staff in their work with suicidal patients and a positive impact is noted of training in sucidology and supervision on job clarity. These problems were more in nurses and assistant nurses than among the psychiatrists.[11] The tendency of those immediately concerned with the patient to deny the occurrence of suicidal events contributes to the difficulty of helping suicidal patients. This occurs not only in the patients caregivers but also with the professional staff involved.[12] Interference into hospital affairs from various quarters related directly or indirectly to the conflict leads to indiscipline. This interference might come from government quarters in the form of arrests, detention and transfer of staff without taking into consideration the effect on the functioning of the hospitals. The pressure from the ultras manifested as weakness in applying strong administrative policies due to a threat perceived by the administrators. This indiscipline percolates to the staff, patients or their attendants thus leading to difficulties in implementing rules and regulations. Many of the people shun their duties and even prefer staying at home without any genuine reason. Non availability and absence of staff leads to stop gap arrangements which in turn affect the quality of work. This indiscipline leads to destruction of the work culture which reflects in the patient care.

All these factors are inter related and a multipronged strategy is needed to deal with these. Education of the public through mass media campaigns about signs and symptoms of suspected poisoning and possible first aid measures. This should also include information about harmful effects of pesticides, safe use, storage and disposal of pesticides along with the use of locked boxes for storage of these chemicals. Previously successful campaigns in mass media have been launched for other programs such a mother child care programs and polio eradication. The use of prominent religious personalities and sermons at the religious places can also play an important role in educating the public. These people have a high regard in the society and people are expected to listen and obey them. Tighter legislation regarding organ phosphorous might also be enforced to make this compound hard to procure as the mortality encountered in poisoning is almost entirely due to this compound. This along with a strict enforcement of drug dispensing procedures from local chemists can help in the goal of prevention of suicidal deaths and attempts. Education and training of doctors at primary level about initial management of patients of poison, signs and symptoms of various poisons, types of patients to be referred to tertiary care. This approach will lead decrease in mortality and lesser number of referrals to the tertiary care hospital thus indirectly saving meager hospital resources for the more needy patients. Next it is imperative that in all insurgent situations doctors be trained in treating poisoning as the expected rate of such cases is expected to rise in such situations. In an atmosphere of violence it is expected that a whole range of poisons may be encountered and in the emergency casualty departments ready referral manuals should be present to deal with all such eventualities.[7] Suicide precautions must be carefully adhered to by the staff and charts regarding the same may be pasted in the emergency rooms. Supervision and specific training of the staff in sucidology are very important to prevent suicidal behavior in the patients in future. Improvement in community psychiatric services and psychiatric outreach programs which are presently nonexistent in our set up can go a long way in decreasing the stress levels in the community and subsequently the suicidal poisoning cases. Mental health in chronic violence settings should receive full attention through the provision of appropriate community-based services that would improve access to care and reduce the burden on the health system.[8] Better organization of the specialized psychiatric services along with coordination with other health care services can lead to improved service delivery for the patients. Sensitization of the medical staff in the hospitals including doctors from other specialties for better management and follow up of suicidal cases is essential for better treatment outcome. In Kashmir programs *helping the helpers* have been scarce even though literature concerning such programs is increasing worldwide. In view of the results of our study the department of psychiatry has been trying its best to educate the hospital staff and the community by outreach programs. However all these approaches can work for short term basis but redressal of the main problem of resolving the conflict can lead to the sustained improvement over long time.

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